L.Ac., M.Ac.O.M.

Debra Joan Wood

JAPANESE & CHINESE ACUPUNCTURE
CHINESE HERBAL MEDICINE

Fertility Treatment History

We ask that you take the time to fill out this history as carefully and completely as possible including dates, results and side effects where appropriate. The more information we have to work with, the better we can understand your body as a whole, and how it has responded to treatment. Thank you for taking the time.

Name_____ Age_____ Date_____

Fertility Clinic_____

Physician_____

Western Medical Diagnosis (if any):

Western Diagnostic Tests and Hormone Panels
(include dates and results):

__ Hysterosalpingogram (HSP)_____

__ Endometrial Biopsy_____

__ Clomid Challenge_____

__ Follicle Stim. Horm. (FSH)_____

__ Leutinizing Horm. (LH)_____

__ Estradiol_____

__ Progesterone _____

__ Prolactin_____

__ Any additional tests _____

GYN related surgeries (dates and outcome):

If past treatment has included any assisted reproductive technologies (ART), please indicate the procedures, dates, medications, your body's response (egg number, egg quality, number of cells, unwanted side effects, etc) and the results. If additional space is needed, please use the back of this page.

Intrauterine Insemination (IUI):

In Vitro Fertilization (IVF):

Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT):